



COMMONWEALTH of VIRGINIA

Department of Health

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UPDATE: FUNGAL MENINGITIS ASSOCIATED WITH CONTAMINATED PRODUCT

October 25, 2012

Dear Clinician,

This letter is being sent to physicians in southwestern Virginia to update you on the outbreak of fungal meningitis among patients who received epidural spinal injections (ESI) containing potentially contaminated preservative-free methylprednisolone acetate from three lots prepared by the New England Compounding Center (NECC). In Virginia, this product was only used by Insight Imaging in Roanoke and New River Valley Surgery Center in Christiansburg between June 28 and September 28, 2012.

As of October 25, 2012, VDH is reporting 43 cases of suspected or confirmed fungal meningitis, including two (2) deaths. See the attachment for a descriptive analysis of Virginia's cases to date. Among patients who had their ESI procedures in September, some are just now developing symptoms and CSF findings of meningitis.

Updated Guidance Regarding Management of Asymptomatic Exposed Persons

On October 23, 2012, CDC released updated guidance suggesting that **"the period of greatest risk for development of fungal meningitis among patients who received epidural or paraspinal injections with contaminated products is during the first 6 weeks (42 days) after injection; therefore, additional monitoring of these patients should be considered."**

(www.cdc.gov/hai/outbreaks/clinicians/guidance_asymptomatic_persons.html)

According to this new guidance:

Clinicians may consider performing a lumbar puncture on asymptomatic patients who received their last epidural or paraspinal injection with contaminated steroid product within the last 6 weeks and may subsequently consider weekly lumbar punctures on these patients until 6 weeks after their last injection. As a reminder, consultation with an infectious disease specialist is strongly recommended for the management of these patients.

Because of these patients' higher risk for developing meningitis, VDH is making it a priority to contact the individuals who had an ESI within the last 6 weeks at either facility. Additionally, we will be working to contact physicians caring for these patients to ensure they have access to the latest CDC clinical guidance.

In Virginia, approximately 50 patients received an injection of the recalled product into a peripheral joint. Evaluation of any patient with a suspected septic arthritis should include sending synovial fluid for fungal smear and culture. To date there has been no report of a suspected fungal infection of a peripheral joint in any Virginia patient.

The VDH homepage (www.vdh.virginia.gov) has links to CDC's Fungal Meningitis Outbreak webpage, which will have the most current guidelines on diagnostic testing and treatment. Please check the guidelines frequently since these recommendations may change as more is learned about this infection.

We hope this information is helpful as you communicate with patients about their symptoms, their risk of infection and as you make clinical decisions regarding diagnostic testing, hospitalization, treatment, and follow-up. Please contact your local health department to report suspected cases or if you need additional information.

Sincerely,

David H. Trump, MD, MPH, MPA
State Epidemiologist & Director, Office of Epidemiology